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General Introduction

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BACKGROUND: THE MAKING OF A CRISIS

The Financial Crisis that arose in 2008, spreading to affect almost all parts of the world, was the result of a range of deeply-rooted economic developments, including deregulation of the financial sector, creation of incentives encouraging excessive risk-taking, and accumulation of risky assets by banks.[1] In a context where complex financial products were traded at extremely high volume, often driven by computerised algorithms, any major upset to the international financial system carried risks of global contagion.

Such an upset occurred in the United States of America (USA) in the autumn of 2008. The subsequent Financial Crisis Inquiry Commission Report attributes the initial shock to the collapse of a housing bubble that had been driven by low interest rates, easily available credit, lax regulation, and resulting subprime lending (offering mortgages on properties for more than they were worth). A rise in interest rates rendered these loans unsustainable and the resulting shock was the ultimate trigger of a seismic collapse of the financial system, not just in the USA, but around the globe[2].

The damage to the world economy was enormous, and the total cost is incalculable. The Gross Domestic Product (GDP) of the European Union (EU) fell by 4.3% in 2009, with a second dip of 0.4% in 2012. The only EU Member State to escape recession altogether was Poland, while some countries (e.g. Estonia, Latvia and Lithuania) lost more than 14% of GDP in a single year. Greece remains, by far, the most notable victim of the financial and economic crisis, losing over a quarter of GDP and, even in 2016, still in recession [3].

Under pressure from major international organisations including the International Monetary Fund (IMF), the European Union, and the European Central Bank, many European countries adopted austerity measures, with the stated aim to reduce the current account deficit [4]. This was extremely controversial, with many economists, from the Keynsian school, arguing that the resulting reduced demand in the economy would either delay recovery or even deepen the recession[5]. Those countries in the Eurozone faced particular challenges. Denied the traditional response of competitive devaluation, they were required to meet the European Commission's condition of maintaining public borrowing below the level of 3% of GDP. The argument that public spending should be increased during recession to revive and strengthen the economy was consistently rejected by governments and international organisations[6, 7].

One reason why austerity policies found favour was a study arguing that growth declined when the public-debt-to-GDP-ratio reached a tipping point of 90% [8], a value already exceeded in some European countries such as Italy, while in others the rising level of debt approached it. Yet it was discovered that this was based on a basic calculation error [9], and the existence of a debt threshold associated with dramatically poorer growth has been refuted[10]. By now, Europe was in a double-dip recession that stretched over four years. Eventually the chief economist of the IMF called for expan-

sionary policies, arguing that fiscal consolidation had been associated with lower than expected levels of economic growth [11].

The economic crisis and accompanying austerity drive that lasted almost half a decade, and in a number of countries continues, to some extent, even now, had disastrous effects on the people of the countries most affected. Unemployment increased from 7% to 11% between 2008 and 2013 across the EU. At its peak, in 2013, it reached 27.5% in Greece, 26.1% in Spain, and 16.4% in Portugal. It rose even more sharply in the Baltic countries, with increases to 19.5% in Latvia, 17.8% in Lithuania and 16.7% in Estonia by 2010, while household incomes fell or stagnated[3]. Absence or dismantling of social safety nets in some countries increased poverty levels, widened socio-economic inequalities, and increased exposure of vulnerable groups to important threats to health [12, 13].

Economic shocks on this scale and depth had profound impacts on national budgets. Decisions on where savings could be made were based on both questionable economic grounds (as described above), but also on political ideology. Although countries differed in where they made the deepest cuts, the health sector, as well as the closely related social care sector, were often among those worst affected.

IMPACT OF THE CRISIS ON HEALTH AND HEALTH SYSTEMS

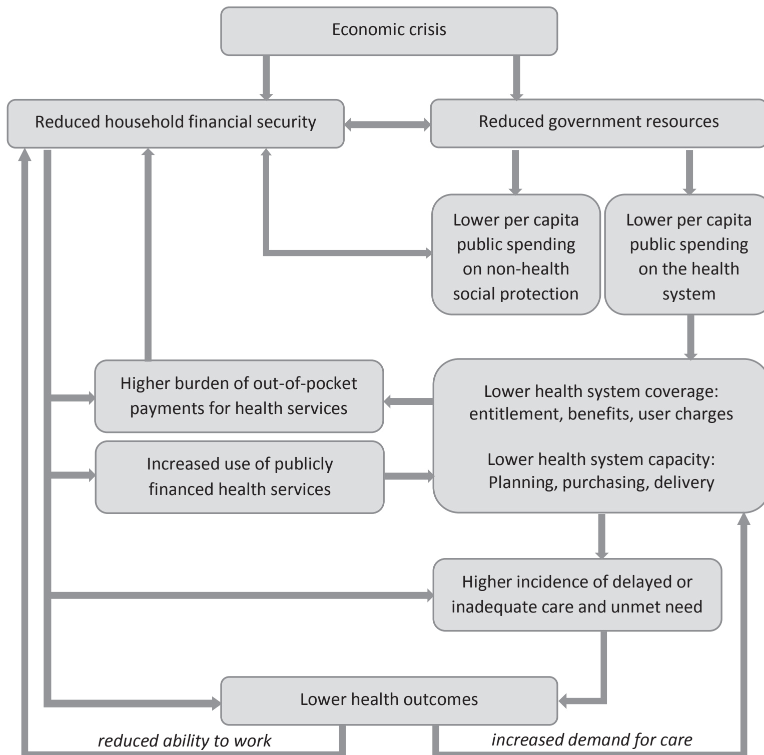
Economic shocks impact on health systems in several ways. Most obviously, they exert pressure on government budgets, reducing the sums available for revenue and capital spending in the health sector. However, their impact on employment and household budgets can increase demand for health care, and in particular mental illness and its physical consequences. Recognising these risks, as early as 2009 there were calls from the public health and health systems communities to take action to mitigate the effects of the economic crisis, such as job loss, reduced income, housing arrears, and generally deteriorating living conditions, and to establish mechanisms to monitor health and implement protective measures in health and social care [14].

However, there were others who argued that recessions can have a positive effect on health. Some of these effects were uncontroversial, such as fewer road injuries consequent on declines in traffic volume or reduced affordability of health-damaging products, such as cigarettes and alcohol. However, some research showing reductions in mortality during recessions in high-income countries [15-17] was contested, with critics arguing that they may not have accounted for lagged effects related to some of the causes of death or for coincidental events, such as the effects of the epidemiological transition during the Great Depression of the 1920s and 1930s[18].

Turning specifically to the relationship between an economic crisis and the health system, Figure 1 describes two possible pathways, as outlined by Thomson et al [19]. The first

pathway involves reduced financial security of households, with consequences for the individuals concerned (e.g. unemployment, falling income). This can either lead to lower health outcomes directly (e.g. through stress, increase in engaging in risky behaviours) or indirectly by reducing the probability that those with health needs will have them met by the health system (e.g. due to burden of out-of-pocket payments). Ill-health, in turn, may reduce an individual's ability to work, which further reduces financial security. The second pathway is through a reduced public health system budget, which may lead to reduced health care coverage or impair the system's capacity to deliver timely and quality care. This can reduce access to health services, damaging health outcomes. Importantly, these pathways can interact, creating multiple pressures. For instance, households with reduced incomes pay less tax and receive greater benefits, reducing the revenues available to the government in general and the health system in particular; and increased use of publicly funded services adds to pressure on health service delivery. These pathways are influenced by diverse policy choices, many of which have their origins outside of the health sector. National fiscal policies shape public spending, including that on social protection, and determine household exposure to financial insecurity.

Figure 1. Pathways to lower health outcomes during an economic crisis



Source: Adapted from Thomson et al (2015) [19]

From an individual level perspective, maintaining work and income is key during recession. Stuckler et al found previously that higher levels of social spending and the maintenance of effective social welfare nets, and especially employment protection mechanisms, can mitigate the adverse health impact of an economic crisis on health, specifically by reducing rates of suicide [14, 20].

From a health system perspective, even when there are severe economic shocks and powerful fiscal pressures, health policy makers are presented with a choice of policy options [21]. These have been summarised by Thomson et al [19] as:

- Attempt to get more out of available resources through efficiency gains;
- Cut spending by restricting budgets, inputs or coverage of health services;
- Mobilise additional revenue.

Maximising efficiency has been one of the key objectives of health systems in high income countries for decades.[22] Consequently, when the crisis hit, the scope for additional efficiency gains was limited in many high income countries. This did not mean that nothing could be done; but further actions required time and, in many cases, investment in new models of delivery, for which it was difficult to raise funds. Given the perceived need for rapid action, cutting spending seemed inevitable.

Finding areas where cuts can be made without adverse impacts on service provision is challenging. Arbitrary cuts are likely to result in inefficiencies in healthcare in the long term. They can result in rationing of services, either implicitly (e.g. creating incentives for informal payments or service dilution) or explicitly (e.g. reducing coverage by excluding people or services, increasing user fees, or prolonging waiting times). Such measures risk undermining financial protection, access to services and overall transparency of the system. Therefore the only option for administering cuts without damaging service provision is to disinvest in non-cost-effective services – a process which requires a strong evidence base, coupled with excellent health technology assessment capacity.

As much of the evidence shows, during the crisis health systems need more, not fewer resources, therefore ability to mobilise revenue is key to maintaining health systems performance levels. A number of mechanisms, including countercyclical spending or creation of reserve funds exist, however they need to be in place before the onset of the crisis.

There were a number of countries in the EU where the crisis had a much more profound impact on the economy. Economies of those in the Baltic region – Estonia, Latvia and Lithuania have managed to recover quickly. Others – Ireland, Greece, and Portugal, had to be bailed out by "the Troika" (the European Commission, International Monetary Fund and the European Central Bank). Each government was required to sign up to a series of "economic adjustment programmes" (EAP) which detailed their obligation to implement specific measures across a range of sectors. In Greece and Portugal, the programmes

(started in 2010 and 2011 respectively) involved specific measures directed at the health sector [23, 24], demanding rapid savings but restricting the number of options available to policy makers (see Chapter 2).

SCOPE, RELEVANCE AND AIMS OF THE THESIS

The impact of the Global Financial Crisis on European economies was monitored and reported in almost real-time, but largely from the financial perspective. The impact on European health systems, in contrast, gained little prominence, even among those responsible for health policy making. Although the onset of the crisis was in the United States, it was European countries, which faced the deepest and longest recessions.

European countries offer a unique opportunity to study the effects of the financial crisis. They are united by similar values and cultures; prior to the crisis they were in similar economic situations, and as members of the European Union, they are subject to the same supra-national legal and regulatory systems. Yet their health policies remain largely a matter of national responsibility, as governments retain competence for organisational structures, governance arrangements and levels and modes of funding and coverage. These differences mean that they vary in their ability to withstand shocks, such as an economic crisis.

For these reasons, in this dissertation I ask how population health and health systems of Europe have been impacted by the crisis and how they responded, and I describe the short- to mid-term consequences for health. I pay particular attention to those countries, such as Greece, Portugal, and the Baltic States, which had the deepest recessions, as these offer especially illuminating country case studies.

The specific aims of the thesis are as follows:

- ***Assess the consequences of the economic crisis of 2008 for population health;***
- ***Assess the impact of the crisis on health systems and identify responses that help countries to maintain stability and promote resilience.***

In the discussion, I will also highlight the implications of the findings of this thesis for health policy and future global health.

The terms "Global Financial Crisis", "economic crisis" and "recession" are used in this dissertation interchangeably, referring to the aftermath of the event that shook global economies in late 2008 and, for some countries, have not yet concluded.

This thesis not only enriches the scientific body of knowledge on the topic, but identifies a broad set of options available to health policy makers at times of severe financial constraints. It also uses country case studies to identify lessons, which can be learned from the experience of undergoing a severe recession. The set of studies included in

this thesis has already been used widely, not only to stimulate further research on the impact of the crisis, but also to inform policy making at the national [25, 26] as well as international level [19, 27].

STRUCTURE OF THE THESIS

This thesis is a compilation of scientific reports united by the common theme of the impact of the financial crisis, recession, and austerity policies on population health and health systems. It provides an overview of existing literature as well as original analyses of health sector policies, population surveys and mortality data in selected European countries.

The core of this dissertation consists of two parts. The first part consists of four chapters, focussing on the general impact of the crisis across Europe. Chapter 2 provides the background to the financial crisis, a review of literature on the association between recessions and health, presents initial responses of countries within the WHO European Region, and outlines the content of the Economic Adjustment Programmes in Greece and Portugal. Chapter 3 is an analysis of longitudinal data, asking whether employment protection policies played a mitigating role, allowing people in ill health to remain employed during the recession. Chapter 4 is a narrative literature review on the effects of the crisis on health in selected countries up to 2015. Chapter 5 is a time series analysis of amenable mortality data across Europe asking whether trends have changed with the onset of the crisis.

The second part contains country-specific studies, from Greece, Portugal and the Baltic States (Lithuania, Latvia and Estonia). This part highlights their differing circumstances, while analysing the impact of specific policies on population health and health systems. Greece and Portugal were chosen as countries required to accept a bailout, with their policy options being restricted by the conditionalities of the Memorandum of Understanding (MOU) within Economic Adjustment Programmes imposed by the international lenders. The Baltic States suffered deep but short-lived economic shocks and responded in different ways, with differing impacts on access to care.

Finally, a general discussion of the findings from papers presented in this volume will summarise the lessons learned and will present policy options. The dissertation is concluded with a summary, list of references and appendices.

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